PRINTED: 02/27/2013 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155252	B. WIN	G		02/04	/2013
NAME OF I	PROVIDER OR SUPPLIER	R	•	STREET	ADDRESS, CITY, STATE, ZIP CODE		
					RAME RD		
GOLDEN	N LIVING CENTER-	WOODLANDS		NEWB	URGH, IN 47630		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	ode Recertification and	K00	000	Preparation and submission of	nf.	
	-	Survey was conducted by	Koc	700	this Plan Of Correction does in		
		e Department of Health in			constitute any admission or		
		42 CFR 483.70(a).			agreement of any kind by the		
	accordance with	142 CFR 465.70(a).			facility of the truth of any		
	Cumusus Datas Of	2/04/12			conclusion set forth in this allegation. Accordingly, the		
	Survey Date: 02/04/13				facility has prepared and subr	nits	
	F				this Plan of Correction solely		
	Facility Number: 000155 Provider Number: 155252				requirement under State and		
					Federal Law that mandates a		
	AIM Number:	100266830			submission of a Plan of Correction as a condition to		
					participate in Title 18 and 19		
	-	Brashear, Life Safety			programs, and to provide the	best	
	Code Specialist		possible care to our residents as		as		
					possible.		
		ety Code survey, Golden					
	_	Voodlands was found not					
	in compliance w	vith Requirements for					
	•	Medicare/Medicaid, 42					
		3.70(a), Life Safety from					
	Fire and the 200	0 edition of the National					
	Fire Protection A	Association (NFPA) 101,					
	Life Safety Code	e (LSC), Chapter 19,					
	Existing Health	Care Occupancies and					
	410 IAC 16.2.						
	This one story fa	acility was determined to					
	be of Type V (0	00) construction and was					
	fully sprinklered	d. The facility has a fire					
	alarm system wi	ith hard wired smoke					
	1	corridors and spaces open					
		plus battery operated					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

smoke detectors in all resident sleeping

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 01	(X3) DATE : COMPL		
	. , ,	155252		LDING		02/04/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	PROVIDER OR SUPPLIER				RAME RD		
GOLDEN	I LIVING CENTER-	WOODLANDS		NEWBU	IRGH, IN 47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1.10		lity has a capacity of 114		1110			5.112
		s of 108 at the time of this					
	survey.						
		residents have customary					
	-	nklered. All areas					
	providing facility						
	_	ept three detached lastic shed, one wood					
		d one wood framed					
		I siding used for facility					
	storage.	r orunng upour for ruenney					
	C						
	Quality Review	by Robert Booher, Life					
	-	cialist-Medical Surveyor					
	on 02/13/13.						
	The facility was	found not in compliance					
	-	entioned regulatory					
	requirements as						
	following:	Ž					

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Event ID: TTB421

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155252			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/04/2013		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630				
(X4) ID PREFIX TAG K0018	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
SS=E	LIFE SAFETY CO Doors protecting than required end openings, exits, of substantial doors of 1¾ inch solid-be capable of resisting minutes. Doors in only required to resisting minutes. There is closing of the door with a means suit closed. Dutch do permitted. 19.3 Roller latches are regulations in all le Based on observe facility failed to dining room dou were equipped we latched into their deficient practice residents, staff, a main dining room Findings include Based on observe p.m. during a tot Maintenance Dir double doors fro corridor did not a frames. Furthern	corridor openings in other closures of vertical or hazardous areas are a such as those constructed conded core wood, or any fire for at least 20 in sprinklered buildings are easist the passage of no impediment to the ors. Doors are provided able for keeping the door ors meeting 19.3.6.3.6 are 6.6.3 It prohibited by CMS inealth care facilities. action and interview, the ensure 2 of 2 sets of ble doors to the corridor with positive latches and it door frames. This is ecould affect up to 92 and visitors while in the order. It is action on 02/04/13 at 1:38 are of the facility with the elector, the two sets of on the dining room to the latch into their door more, the dining room of the dining room of the with smoke detection.	K0018	K 018 The corrective actions accomplished for those residents found to have bee affected by the deficient practice are as follows:Corrective action take consisted of contacting TriSta Fire Protection Services to ha wire 6 smoke detectors in the main dining room. Other residents having the potentit to be affected by the same deficient practice will be identified and the corrective actions taken are as follows residents affected equally. measures put into place and the systemic changes made ensure that this deficient practice does not recur are a follows:TriState Fire Protection.	en tte urd al :All The I to		

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		ER/SUPPLIER/CLIA FION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	01 	COMPLETED 02/04/2013				
	PROVIDER OR SUPPLIER I LIVING CENTER-WOODLAN	IDS	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630						
(X4) ID PREFIX TAG	SUMMARY STATEMENT O (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	Maintenance Director at the observation. 3.1-19(b)			Services hard wired 6 smoke detectors in the main dining room. These corrective actions will be monitored and quality assurance program implemented to ensure the deficient practice will not recept the following: No further corrective action or monitoring required once smoke detector are installed. Systemic changes will be completed by 3/6/13	d a cur				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155252	B. WIN			02/04/	2013
NAME OF B	DOLUBED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			4088 FF	RAME RD		
	LIVING CENTER-\	WOODLANDS		NEWBL	JRGH, IN 47630		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0021 SS=E	enclosure, horizon hazardous area e by devices arrang all such doors by facility upon activate) the required match b) local smoke desmoke passing the	cit passageway, stairway intal exit, smoke barrier or inclosure is held open only ged to automatically close zone or throughout the ation of: anual fire alarm system; etectors designed to detect irough the opening or a					
	c) the automatic sinstalled. 19.2.2 Based on observe facility failed to service metal rol only by a device close upon activa system. This defaffect up to 92 reand visitors whill room. Findings include	ation and interview, the ensure 1 of 1 kitchen ling doors was held open arranged to automatically ation of the fire alarm ficient practice could esidents as well as staff e in the main dining : ation on 02/04/13 at 1:45	K00	021	K 021 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Construction company contact to review and enclose window with solid construction eliminat window. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective	ed ting e e	03/06/2013
	Maintenance Dir service door betw dining room was and fusible link we the door to close	rector, the metal rolling ween the kitchen and held open with a chain which would not allow automatically when the h is actuated. Based on			actions taken are as follows: All residents affected equally. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Window to kitchen was sealed		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		155252	B. WING		02/04/2013
	PROVIDER OR SUPPLIE		4088 F	ADDRESS, CITY, STATE, ZIP CODE RAME RD	
	I LIVING CENTER-			URGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
PREFIX	(EACH DEFICIENT REGULATORY OF interview at the Maintenance Dimetal roller door dining room was and fusible link	time of observation, the rector acknowledged the retween the kitchen and sheld open with a chain which would not allow a automatically when the	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	01	COMPLE	ETED
		155252	B. WIN			02/04/2	2013
NAME OF B	AD CAMPED OR GARDA IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L		4088 FI	RAME RD		
	LIVING CENTER-	WOODLANDS		NEWBL	JRGH, IN 47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0025 SS=E	NFPA 101 LIFE SAFETY CO	ODE STANDARD					
33-E		re constructed to provide at					
		our fire resistance rating in					
	accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are						
		rated glazing or by wired					
		steel frames. A minimum ompartments are provided					
		mpers are not required in					
		of smoke barriers in fully					
	ducted heating, v						
		ems. 19.3.7.3, 19.3.7.5,					
	19.1.6.3, 19.1.6.4						
		ervation and interview,	K00)25	K 025		03/06/2013
	the facility failed	l to ensure 2 of 9 smoke					
	barrier walls pro	vided at least a one half			The corrective actions		
	hour fire resistan	nce rating. This deficient			accomplished for those residents found to have been	,	
	practice could af	fect 9 residents, as well			affected by the deficient	'	
	as staff and visit	ors in the 200 hall.			practice are as follows:		
					Corrective action consisted of	all	
	Findings include	<i>:</i>			small penetrations being seale	:d	
					with fire barrier seal caulking.		
	Based on observ	ations on 2/04/13			Other residents having the		
	between 11:30 a.	.m. and 2:30 p.m. during			potential to be affected by the	е	
	a tour of the faci	lity with the Maintenance			same deficient practice will b	e	
	Director, the smo	oke barrier wall above the			identified and the corrective		
	·	ne 200 west smoke barrier			actions taken are as follows:		
		nch gap through the wall			No other residents affected. The measures put into place		
		kler pipe, furthermore,			and the systemic changes		
	-	er wall above the 200 hall			made to ensure that this		
		er doors had three			deficient practice does not		
					recur are as follows:		
	-	ough the wall which were			Maintenance department to		
		The penetrations were			inspect all area walls on		
		luits and one sprinkler			completion of any subcontract job to ensure no break of the	ea	
		size from one half inch to			smoke barriers. If any areas a	re	
	one inch. This w	vas acknowledged by the			I arrivated at the state of the	~	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M			(X3) DATE SURVEY	·	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLETED	
		155252	B. WIN	G		02/04/2013	
	PROVIDER OR SUPPLIE		•	4088 FF	ADDRESS, CITY, STATE, ZIP CODE RAME RD JRGH, IN 47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5	5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLE	ETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DAT	E
	Maintenance Di	rector at the time of			discovered, they will be sealed	l	
	observation.				with fire barrier seal caulking.		
	3.1-19(b) 2. Based on obsthe facility faile smoke barriers a one half hour LSC 8.3.2 requibe continuous froutside wall. Tould affect 12 visitors and staff Findings include Based on observations and staff with the Mainte hall Janitor's Classical foot section of continuous front section section of continuous front section section of continuous front section section section section of continuous front section sec	vation on 02/04/13 at ng a tour of the facility nance Director, the 600 oset had a one and a half reiling drywall which had with new drywall. The new a finished which left a half ot long open to the attic.			These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not receper the following: Maintenance will report any deficient practice to executive director who will report in QA monthly X 6 months unless further monitoring is deemed necessary at that time. Systemic changes will be completed by 3/6/13		
	3.1-19(b)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED	
		155252	B. WIN			02/04/2013	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				RAME RD		
	LIVING CENTER-	WOODLANDS		NEWBL	JRGH, IN 47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE	DAT	E
K0038 SS=E	NFPA 101 LIFE SAFETY CO	ODE STANDARD					
33-E		anged so that exits are					
	readily accessible at all times in accordance						
	with section 7.1.						
	1. Based on obs	ervation and interview,	K00	38	K 038	03/06/	2013
	the facility failed	I to ensure 3 of 3 access					
	doors to the courtyard which were equipped with delayed egress locks were				The corrective actions		
					accomplished for those		
		gns stating PUSH UNTIL			residents found to have beer affected by the deficient		
	1 *	DS DOOR CAN BE			practice are as follows:		
	OPENED IN 15				Corrective action included place	ing	
					order for the "Push until door		
	7.2.1.6.1,says approved, listed, delayed egress locks shall be permitted to be				sounds,, door can be opened		
	_	rs serving low and			15 seconds" and "No Exit" sign		
		contents in buildings			Maintenance request complete for ACU keypad repair, gates to		
	1	•			be trimmed to swing freely, an		
	-	hout by an approved,			one gate hinge changes in ord		
	•	natic fire detection			to swing in path of egress.		
	*	ance with Section 9.6, or			Requested bids for sidewalk to)	
		pervised automatic			extend around eastside of building to reach a public way.		
		in accordance with			building to reach a public way.		
	· ·	where permitted in					
	_	ugh 42, provided the			Other residents having the		
	_	a are met. (a) The doors			potential to be affected by th		
	shall unlock upo	n actuation of an			same deficient practice will b	e	
	approved, superv	vised automatic sprinkler			identified and the corrective actions taken are as follows:		
	system in accord	ance with Section 9.7 or			All residents could be affected	.	
	upon the actuation	on of any heat detector or					
	activation of not	more than two smoke					
	detectors of an a	pproved, supervised			The measures put into place		
		etection system in			and the systemic changes		
		Section 9.6. (b) The			made to ensure that this		
		ck upon loss of power			deficient practice does not recur are as follows:		
	controlling the lo	• •			Signs posted on all 3 doors		
	_	An irreversible process			indicating "Push until alarm		
	1110011011113111. (0)	in moversione process					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLE	TED
		155252	B. WIN			02/04/2	2013
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t .			RAME RD		
COLDEN	I LIVING CENTER-	WOODI ANDS			JRGH, IN 47630		
GOLDEN	I LIVING CENTER-	WOODLANDS		NEWBC	JRGH, IN 47030		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	shall release the	lock within 15 seconds			sounds door can be opened in	15	
	upon application	of a force to the release			seconds" and "No Exit" sign		
	device required	in 7.2.1.5.4 that shall not			posted on the 2 doors to the		
	be required to exceed 15 lbf nor be required to be continuously applied for				courtyard with no further corrective action required.		
					ACU keypad to the outside ga	ate	
					repaired and will be checked for		
	more than 3 seconds. The initiation of the release process shall activate an audible				proper functioning weekly and		
					documented for proper functio		
	•	nity of the door. Once			weekly. Both gates in ACU		
	the door lock has	s been released by the			courtyard were trimmed to allo	w	
	application of fo	rce to the releasing			the gates to swing freely.		
	device, relocking shall be by manual means only. Exception: Where approved				One gate repaired with hinges reconnected to allow gate to		
					swing in the path of egress. N		
		having jurisdiction, a			further corrective action require		
	l •	- ·			Bids obtained for sidewalk to	ou.	
		ling 30 seconds shall be			extend around building but mu	st	
		on the door adjacent to the			wait until weather breaks for		
	releasing device	, there shall be a readily			installation.		
	visible, durable s	sign in letters not less					
	than 1 inch high	and not less than 1/8 inch			These corrective actions will		
	in stroke width o	on a contrasting			be monitored and a quality		
		reads as follows: PUSH			assurance program		
	_	I SOUNDS DOOR CAN			implemented to ensure the		
		I 15 SECONDS. This			deficient practice will not rec per the following:	ur	
					Maintenance will report		
	_	e could affect up to 10			functioning of the ACU gate		
	· ·	l as staff and visitors			keypads to the executive direct	tor	
	while in the cour	rtyard.			who will report in QA monthly		
					months unless further reporting	-	
	Findings include	::			deemed necessary at that time	Э.	
	Based on observ	rations on 02/04/13			Systemic changes will be		
		.m. and 2:30 p.m. during			completed by 3/6/13. An		
					extension is requested for installation of the sidewalk		
		lity with the Maintenance			weather allowing, to be		
		e doors to the courtyard			completed with in 90days.		
		vith delayed egress locks			,		
	and were not pro	ovided with signs					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLE	TED
		155252	B. WIN			02/04/2	013
NAME OF F			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	· ·		4088 FF	RAME RD		
	I LIVING CENTER-	WOODLANDS		NEWBL	JRGH, IN 47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	_	TAG	DEFICIENC!)	+	DATE
		H UNTIL ALARM					
		R CAN BE OPENED IN					
	15 SECONDS. This was acknowledged by the Maintenance Director at the time						
	of each observation. 3.1-19(b)						
	2. Based on observation and interview,						
		d to ensure 2 of 3 doors to					
	1	ere provided with signs					
		EXIT". 7.10.8.1 requires					
		ge, or stairway that is					
	' ' '	•					
		or a way of exit access					
		arranged so it is likely to					
		an exit shall be identified					
	•	ads as follows: NO					
		n shall have the word NO					
		es high with a stroke					
	width of 3/8 incl	h and the word EXIT in					
	letters 1 inch hig	gh, with the word EXIT					
	below the word	NO. This deficient					
	practice could at	ffect any of the 92					
	residents outside	e of the Alzheimer's Care					
	Unit, as well as	staff and visitors while					
	· · · · · · · · · · · · · · · · · · ·	obby or the west sitting					
	area.						
	Findings include	2:					
	Dagad on abases	vations on 02/04/13					
		.m. and 2:30 p.m. during					
		ility with the Maintenance					
	Director, the doo	or from the west sitting					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 01	(X3) DATE (COMPL		
1111212111	or condition.	155252	A. BUII			02/04/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RAME RD		
GOLDEN	I LIVING CENTER-	WOODLANDS		NEWBU	JRGH, IN 47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	TE	COMPLETION
TAG		tyard and the door from		TAG	DLI ICILICI I		DATE
		o the courtyard were not					
		gns stating "NO EXIT".					
	This was acknow	•					
		rector at the time of each					
	observation.	over we will think of swell					
	3.1-19(b)						
		ervation and interview,					
	the facility failed to ensure 1 of 2 exterior gates from the Alzheimer's Care Unit						
	1 -						
	, ,	area, which was access controlled egress					
		locking device connected					
		system, automatically					
		he fire alarm system was					
		ection 19.2.1 refers to					
		LSC 7.2.1.6.2(d) requires					
	_	building fire protection					
		, if provided, shall					
		lock the doors in the					
		ss, and the doors shall					
	_	until the fire protective					
		has been manually reset.					
	LSC 19.2.2.2.5 s	tates doors located in the					
	means of egress	that are permitted to be					
	locked under oth	er provisions of this					
	chapter shall hav	re adequate provisions					
	_	id removal of occupants					
	1 -	s remote control of locks,					
	1	ks to keys carried by staff					
	•	ther such reliable means					
	available to the s	staff at all times. Only					

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Event ID: TTB421

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	01	COMPLI	ETED
		155252	B. WIN			02/04/	2013
			D. (11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			RAME RD		
GOLDEN	I LIVING CENTER-	WOODLANDS			JRGH, IN 47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL					TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	one such locking	g device shall be					
	permitted on each	ch door. This deficient					
	practice could at	ffect up to 16 residents, as					
	1 ^	visitors in the ACU.					
	West as start with						
	Findings include	D:					
	Based on observ	vation on 02/04/13 at					
	12:50 p.m. durin	ng a tour of the facility					
	with the Mainter	nance Director, the east					
		fenced in area was					
	~	n access controlled egress					
		This gate did not release					
		tic locking device when					
	1	_					
	~	de was pushed by the					
		rector and Certified					
	_	nt (CNA) # 1, however,					
	•	ase from the magnetic					
	locking device v	when the fire alarm system					
	was actuated at 2	2:00 p.m. The					
	Maintenance Di	rector stated it must be					
	the keypad that	was not functioning					
	correctly.	5					
	3.1-19(b)						
	0.1 17(0)						
	4. Based on obs	servation and interview,					
		d to ensure 1 of 2 exterior					
		Alzheimer's Care Unit					
	~						
	` ′	n area, swung in the					
		ess travel. LSC 7.2.1.4.3					
		all swing in the direction					
	of egress travel.	Furthermore, the facility					
	failed to ensure	2 of 2 exterior gates from					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155252	B. WIN	G		02/04/2013
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE	
					RAME RD	
GOLDEN	I LIVING CENTER-	WOODLANDS		NEWBU	JRGH, IN 47630	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		TAG	BEI ICIENCI)	DATE
		in area required no more of force to open. LSC				
		*				
		orces required to fully nanually in a means of				
		exceed 15 lbf to open the				
	~	mum required width.				
		ractice could affect up to				
	_	well as staff and visitors				
	in the ACU.	well as stall and visitors				
	in the ACO.					
	Findings include	•				
	Tillulings illerude					
	Based on observ	ation on 02/04/13				
	between 12:50 p	.m. and 1:05 p.m. during				
	_	lity with the Maintenance				
		thwest gate of the ACU				
	· ·	vung into the fenced in				
		winging in the direction				
		parking lot outside the				
		e, both gates required				
	_	en only half way because				
	_	ch wooden gate dragged				
		sidewalk. This was				
	acknowledged b	y the Maintenance				
	Director at the ti	me of each observation.				
	3.1-19(b)					
		ervation and interview,				
	1	d to ensure not more than				
	one delayed egre	ess locking device was				
	provided in 3 of	10 egress paths. NFPA				
	101 7.2.1.6.1 sta	tes approved, listed,				
	delayed egress lo	ocks shall be permitted to				

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Event ID: TTB421

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	01	COMPL	
		155252	B. WING			02/04/	2013
NAME OF F	PROVIDER OR SUPPLIEI				ADDRESS, CITY, STATE, ZIP CODE		
					RAME RD		
	I LIVING CENTER-	WOODLANDS	N	EWBU	JRGH, IN 47630		
(X4) ID		TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION	RECTION	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
		loors serving low and					
	1	contents in buildings					
	1 *	shout by an approved,					
	_	natic fire detection					
		proved, supervised					
	_	kler system. NFPA 101,					
	1	otion No. 2 requires					
	, ,	ocks complying with					
		e permitted, provided not					
	more than one s	uch device is located in					
	any egress path.	This deficient practice					
	could affect up t	to 46 residents, as well as					
	staff and visitors	s from the 300, 500, and					
	600 halls.						
	Findings include	2:					
	Based on observ	vations on 02/04/13					
	between 2:10 p.i	m. and 2:20 p.m. during a					
	_	ty with the Maintenance					
		t doors from the 300, 500,					
		ere equipped with delayed					
		reach a public way from					
	these exits requi						
	_	walk on the south side of					
	_	ling to the west through					
		gates of the Alzheimer's					
		were both equipped with					
		ocking devices. There					
		from the 500 hall exit to					
		he facility to a public					
		, ,					
	-	a 200 foot grassy area to					
	_	king lot. This was					
	acknowledged b	y the Maintenance					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155252	A. BUILDING B. WING	01	COMI	PLETED 4/2013
	PROVIDER OR SUPPLIER		4088 FF	ADDRESS, CITY, STATE, ZIP RAME RD JRGH, IN 47630	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) me of observations.	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	3.1-19(b)	me of observations.				

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Event ID: TTB421

Facility ID: 000155

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155252	B. WIN			02/04/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		<u> </u>	4088 F	ADDRESS, CITY, STATE, ZIP CODE RAME RD JRGH, IN 47630 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE
K0046 SS=C	NFPA 101 LIFE SAFETY CO Emergency lightir duration is provid 19.2.9.1. Based on record observation; the the documentation battery powered when testing mo annually for 90 r Section 7.9.3 reg shall be conducte emergency lightic intervals for not annual test shall required battery lighting system f hours. Equipmen operational for th Written records of tests shall be kep inspection by the jurisdiction. NF requires EPS (Er equipment locati with battery pow This deficient pr residents, as well the facility. Findings include	DDE STANDARD ng of at least 1½ hour ed in accordance with 7.9. review, interview and facility failed to ensure on for the testing of 3 of 3 light sets was complete inthly for 30 seconds and ininutes. LSC 101, juires a functional test ed on every required ing system at 30 day less than 30 seconds. An be conducted on every powered emergency for not less than 1 1/2 int shall be fully the duration of the test. of visual inspections and of by the owner for e authority having PA 110, Section 5-3.1 intergency Power Supply) ons shall be provided fered emergency lighting. actice could affect all l as staff and visitors in	K00		K 046 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: All battery back up light sets within the facility will be removed. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: No other residents affected. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: All battery back up light sets within the facility will be removed. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recept the following: No further corrective action required once the lights are removed. The building is on 100% generator back-No furth corrective action or monitoring	03/06/2013 n ed e e e e e e e

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UILDING 01	COMPLETED 02/04/2013			
STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630				
PREFIX (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION			
CROSS-REFERENCED TO THE APPROI	PRIATE			
	STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630 ID PREFIX CROSS-REFERENCED TO THE APPROF DEFICIENCY) necessary. Systemic changes will be			

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Facility ID: 000155

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	01	COMPL	ETED
		155252				02/04/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COLDEN	LIVING CENTED I	ALCOCK ANDS			RAME RD		
GOLDEN	LIVING CENTER-	WOODLANDS		NEWBU	JRGH, IN 47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0050	NFPA 101						
SS=C	LIFE SAFETY CO						
		d at unexpected times					
		nditions, at least quarterly					
		e staff is familiar with					
	•	s aware that drills are part utine. Responsibility for					
		ducting drills is assigned					
		t persons who are qualified					
		rship. Where drills are					
		en 9 PM and 6 AM a coded					
	announcement m	ay be used instead of					
	audible alarms.	19.7.1.2					
	Based on record	review and interview, the	K00)50	K 050		03/06/2013
	facility failed to	ensure fire drills were					
	•	nes for 2 of 3 employee			The corrective actions		
		f 4 quarters. This			accomplished for those		
	•	e could affect all residents			residents found to have beer	1	
	•	could affect all residents			affected by the deficient		
	in the facility.				practice are as follows:		
					Reviewed varying times of fire		
	Findings include	:			drills for each shift with maintenance director.		
	Based on review	of the facility's Fire			Other residents having the		
		3 at 11:05 a.m. with the			potential to be affected by th	e	
		rector present, three of			same deficient practice will b		
					identified and the corrective		
		(evening) fire drills			actions taken are as follows:		
		February of 2012 were			All residents affected equally.		
	performed between	een 3:12 p.m. and 4:10					
	p.m., furthermor	e, all four third shift			The measures put into place		
	(night) fire drills	held since February of			and the systemic changes		
	. • /	rmed between 4:37 a.m.			made to ensure that this		
	•	uring an interview at the			deficient practice does not		
		view, the Maintenance			recur are as follows:	.1.1	
					Maintenance department to ho		
		ledged the times of the			a minimum of 1 fire drill per sh per quarter at varied times	IIL	
		shift fire drills were not			through out the shift. A differe	nt	
	varied.				shift to host the fire drill each		
					Similar to most and mo drin oddin		

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	of correction identification number: 155252	(X2) MULTIPLE COI A. BUILDING B. WING	01	COMPLETED 02/04/2013
GOLDEN	PROVIDER OR SUPPLIER I LIVING CENTER-WOODLANDS	STREET A 4088 FR NEWBU		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3-1.19(b)		month. Executive director/designee will review building engines program mon for completion and varied time fire drills.	
			These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not reciper the following: Maintenance director to report executive director the fire drill service held each month with staff which will be reported in 0 X 6 months unless further monitoring is deemed necessate that time. Systemic changes will be completed by 3/6/13	to in QA

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DI 111	LDING	01	COMPL	ETED
		155252				02/04/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COLDEN	LIVING CENTED I	NOODI ANDO			RAME RD		
GOLDEN	LIVING CENTER-	WOODLANDS		NEWBO	JRGH, IN 47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0056	NFPA 101						
SS=E	LIFE SAFETY CO						
		matic sprinkler system, it is					
		dance with NFPA 13,					
		nstallation of Sprinkler					
	•	de complete coverage for building. The system is					
	•	ed in accordance with					
		ird for the Inspection,					
		ntenance of Water-Based					
	Fire Protection Sy						
		e is a reliable, adequate					
		he system. Required					
	'	are equipped with water					
	•	switches, which are					
		cted to the building fire					
	•	19.3.5					
		ation and interview, the	K00)56	K 056		03/06/2013
	facility failed to	provide sprinkler					
	coverage for 1 of	f 6 areas outside and			The corrective actions		
	attached to the b	uilding and constructed			accomplished for those residents found to have beer	_	
	partially of comb	oustible material. NFPA				1	
		at 5-13.8.1 requires			affected by the deficient practice are as follows:		
	sprinklers be inst	talled under combustible			Reviewed with maintenance,		
	exterior roofs or	canopies exceeding four			canopy will be detached from		
		nis deficient practice			building.		
		o 10 residents, staff and			Other residents beging the		
	visitors while us				Other residents having the potential to be affected by th	^	
	visitois willie us	ing courtyard.			same deficient practice will b		
					identified and the corrective		
	Findings include				actions taken are as follows:		
					All residents using the courtya		
	Based on observ	ation on 02/04/13 at 1:55			could be affected.		
	p.m. during a tou	or of the facility with the					
	-	rector, there was a ten			The measures put into place)	
		ot canvas canopy attached			and the systemic changes		
					made to ensure that this		
	•	the courtyard from the			deficient practice does not		
	west sitting room	n door. There was no			recur are as follows:		
I			1		l		i l

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	of Correction identification number: 155252	A. BUILDING B. WING	COMPLETED 02/04/2013
	PROVIDER OR SUPPLIER I LIVING CENTER-WOODLANDS	STREET ADDRESS, CITY, STATE, 4088 FRAME RD NEWBURGH, IN 47630	ZIP CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN (PREFIX (EACH CORRECTIVE AC' CROSS-REFERENCED TC TAG DEFICIEN	TION SHOULD BE OTHE APPROPRIATE CY) COMPLETION DATE
	sprinkler coverage provided under the canopy. Based on interview at the time of observation, the Maintenance Director	Canopy will be det building. No furthe action required.	
	observation, the Maintenance Director said there was no documentation available to show the canopy was flame retardant and also acknowledged there was no sprinkler coverage under the canopy. 3.1-19(b)	These corrective be monitored and assurance progra implemented to e deficient practice per the following: No further correcti required once can from the building. Systemic change completed by 3/16	I a quality Im Insure the Insure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	01	COMPL	ETED
		155252				02/04/	/2013
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				RAME RD		
COLDEN	LIVING CENTER-V	MOODI ANDS			URGH, IN 47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0062	NFPA 101	ODE CTANDADD					
SS=E	LIFE SAFETY CO						
		tic sprinkler systems are ntained in reliable operating					
		inspected and tested					
		0.7.6, 4.6.12, NFPA 13,					
	NFPA 25, 9.7.5	,,					
	1. Based on obs	ervation and interview,	K00	062	K 062		03/06/2013
		to ensure 5 of over 500					
	-	n the facility were free of			The corrective actions		
	•	1 Section 9.7.5 refers to			accomplished for those		
	•	ard for the Inspection,			residents found to have been	า	
		•			affected by the deficient		
	O ,	intenance of Water-Based			practice are as follows:		
		Systems. NFPA 25			Tri State Fire Protection contacted for review and repair	ir of	
	2-2.1.1 requires	sprinklers to be free of			the fire sprinkler heads. Sprin		
	paint. Any sprin	kler shall be replaced that			heads noted to be painted we		
	is painted. This	deficient practice could			replaced. Maintenance ensur		
	affect any of the	9 residents, as well as			sprinkler heads were free of d	ust	
	staff and visitors	while in the 200 hall and			and lint additional spare		
	Laundry area.				replacement heads ordered.		
	Eduliary area.				Wires wrapped around the		
	Findings in stude				sprinkler pipe on the ACU was removed and pipe hanger	5	
	Findings include	·-			installed.		
		ations on 02/04/13			Other residents having the		
		.m. and 2:30 p.m. during			potential to be affected by th	е	
	a tour of the faci	lity with the Maintenance			same deficient practice will b	е	
	Director, the spri	inkler head in resident			identified and the corrective		
	room 207 was pa	artially covered with			actions taken are as follows:		
	paint, furthermor	re, four of five sprinkler			All residents have the potentia	ıl to	
	•	dry room were partially			be affected equally.		
		nt and dust or lint. This					
	•	ed by the Maintenance			The measures put into place		
		me of each observation.			and the systemic changes		
	Director at the th	me of each observation.			made to ensure that this		
					deficient practice does not		
	3.1-19(b)				recur are as follows:		
					1		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			IRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 01			TED
		155252				02/04/20	013
			B. WIN		ADDRESS CITY STATE OF CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
001 DE	LLIVING GENTED	WOOD! ANDO			RAME RD		
GOLDEN	N LIVING CENTER	-WOODLANDS		NEWBU	JRGH, IN 47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTIO			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Tri State Fire Protection replace		
	2. Based on ob	servation and interview,			sprinkler heads with any noted		
		ed to ensure 2 of 2			paint. Maintenance has clean		
		kler head storage cabinets			the laundry sprinkler heads fre		
	_	with at least two of each			of dust and lint. Fire sprinkler heads in laundry will be monite		
	•				monthly for dust and lint by	Jica	
		r head used in the facility.			maintenance. Maintenance w	ill I	
		.4 requires a minimum of			inspect any areas of painting t		
	two sprinklers of	of each type and			outside contractors to ensure		
	temperature rati	ing installed shall be			sprinkler heads have no noted		
	stored in a cabin	net on the premises for			paint. Any sprinklers found wi		
	replacement pu	rposes. This deficient			paint will be cleaned or replace	ed.	
		ffect all residents, as well			Maintenance has purchased additional sprinkler heads and	will	
	•	tors in the facility.			have a minimum of at least 2	VVIII	
	as starr and visi	tors in the facility.			spares for each type of sprinkl	er	
	F: 1: : 1 1				head at all times. Supply will I		
	Findings includ	e:			reviewed monthly with		
					preventative maintenance		
	Based on obser	vations on 02/04/13			program. Metal wires were		
	between 11:30	a.m. and 2:30 p.m. during			removed from sprinkler piping		
	a tour of the fac	ility with the Maintenance			and pipe hanger was installed with no other corrective action		
		o spare sprinkler head			required.		
		facility had six spare			required.		
		each, but, only included			These corrective actions will		
	-	_			be monitored and a quality		
	_	orinkler head and no quick			assurance program		
		nt type sprinkler heads.			implemented to ensure the		
		sprinkler heads were a			deficient practice will not rec	ur	
		r pendent type sprinkler			per the following:		
	heads and uprig	ht type sprinkler heads.			Maintenance will report finding	gs	
	Sidewall sprink	ler heads and quick			and trends to the executive		
	response sprink	ler heads were observed in			director who will report in QA monthly X6 months unless fur	ther	
		ng the tour. This was			monitoring is deemed necessary		
	_	by the Maintenance			at that time.	´	
		time of observation,					
					Systemic changes will be		
	·	e Maintenance Director			completed by 3/6/13		
	indicated there	were no other spare					

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155252		A. BUILDING	01	02/04/2013	
		155252	B. WING		
NAME OF F	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COL	DE
GOLDEN LIVING CENTER-WOODLANDS				FRAME RD FURGH, IN 47630	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	CTION (X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	sprinkler heads i	n the facility.			
	3-1.19(b)				
	3. Based on obs	ervation and interview,			
		d to ensure 1 of 2			
	automatic sprink				
	•	intained. NFPA 25,			
	2-2.2 states sprir	nkler piping shall not be			
	subjected to exte	ernal loads by materials			
	either resting on	the pipe or hung from the			
	pipe. This defici	ent practice could affect			
	up to 62 resident	ts, as well as staff and			
	visitors in the we	est unit of the facility.			
	Findings include	»:			
	Based on observ	ration on 02/04/13 at			
	12:45 p.m. durin	g a tour of the facility			
	with the Mainter	nance Director, there were			
	two metal wires	wrapped around a three			
	inch sprinkler pi	pe as well as a gas pipe			
	above in the Alz	heimer's Care Unit			
	Mechanical Roo	m. At the time of			
	observation it wa	as unclear whether the			
	gas pipe was sup	pporting the sprinkler pipe			
	with the wire, or	the wire was wrapped			
		kler pipe for another			
	reason. Based o	n interview at the time of			
	observation, the	Maintenance Director			
	said he was not a	aware of the wire			
	wrapped around	the sprinkler pipe but			
	would find out v	why it was there and have			
	it removed.				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155252	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/04/2013
NAME OF F	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVING CENTER-	WOODLANDS		RAME RD JRGH, IN 47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155252		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE X3) DATE SURVE COMPLETED 02/04/2013		ETED			
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS					RAME RD JRGH, IN 47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0074 SS=D	curtains, and othe and films serving decorations in he in accordance with NFPA 13, Standa Sprinkler System accordance with least of the service of the servi	as, including cubicle er loosely hanging fabrics as furnishings or alth care occupancies are h provisions of 10.3.1 and rds for the Installation of s. Shower curtains are in NFPA 701. upholstered furniture occupancies meets the when tested in accordance cited in 10.3.2 (2) and , NFPA 13 mattresses meet the when tested in accordance sited in 10.3.2 (3) , 10.3.4. ation and interview, the ensure 1 of 4 sprinklered ere provided with 18 ace from the ceiling to the bicle curtain mesh for effective. NFPA 13, equires the distance tion for pendant or s to be 18 inches if the re feet or more from the leficient practice could at a time, plus staff in the room.	K00	074	K 074 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Shower curtains with mesh extended to the ceiling have boordered. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: 93 residents have the potential be affected.	een e e	03/06/2013

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	OF CORRECTION	IDENTIFICATION NUMBER: 155252	A. BUILDING B. WING	<u>01</u>	COMPLETED 02/04/2013		
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS			STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH, IN 47630				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	with the Mainter hall shower roor curtains with no ceiling. When the closed there wood coverage in that This was acknown	g a tour of the facility nance Director, the 400 n had two cubicle mesh that extended to the ne cubicle curtains were all be no sprinkler area of the shower room. wledged by the rector at the time of		The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Shower curtains were replace with cubicle curtains with mest that extends to the ceiling. No other corrective action require These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recept the following: No further corrective action required once the cubicle curtains are replaced. Systemic changes will be completed by 3/6/13	d h o d.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)			3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01		COMPLETED		
155252		B. WING 02/04/2013				2013	
			Б. WПV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					RAME RD		
GOLDEN	LIVING CENTER-	WOODLANDS			JRGH, IN 47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0143	NFPA 101						
SS=E	LIFE SAFETY CO Transferring of ox						
	Transletting of 07	kygen is.					
	(a) separated from	n any portion of a facility					
		are housed, examined, or					
		ration of a fire barrier of					
	1-hour fire-resistiv	ve construction;					
	//-> : +/	4 in manufacturing the constitute of					
		t is mechanically ventilated,					
	sprinklered, and has ceramic or concrete flooring; and						
	(c) in an area posted with signs indicating that transferring is occurring, and that						
		mediate area is not					
	•	rdance with NFPA 99 and					
	the Compressed 8.6.2.5.2	Gas Association.					
		ation and interview the	K01	13	K 143		03/06/2013
	Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transferring		IXO	.TJ	The corrective actions		03/00/2013
					accomplished for those		
		provided with at least a 1			residents found to have been		
		e constructed ceiling.			affected by the deficient		
			practice are as follows:	14-			
	,	well as staff and visitors			Construction company notified review oxygen storage room for		
	•	gh 600 halls during time			installation of additional ceiling		
	-	ng room which was in the			instandion of dualitional coming.	•	
		rier as the oxygen			Other residents having the		
	storage/transfer	room.			potential to be affected by th		
					same deficient practice will b	e	
	Findings include	:			identified and the corrective		
	-				actions taken are as follows: No other residents affected.		
	Based on observ	ation on 02/04/13 at 1:30			TWO OTHER TESTUENTS ATTECTED.		
		or of the facility with the			The measures put into place		
	-	rector, the oxygen			and the systemic changes		
		room had four liquid			made to ensure that this		
	_	-			deficient practice does not		
	oxygen tanks sto	red inside. The room	1				I

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-WOODLANDS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LESS INFORMATION) TAG REGULATORY OR LES DIENTIFYING INFORMATION) was provided with only a single layer of five eights inch drywall on the ceiling which did not meet the one hour fire resistance rating. The Maintenance Director confirmed this room was used for oxygen storage and oxygen transferring at the time of observation. 3.1-19(b) STREET ADDRESS, CITY, STATE, ZIP CODE 4088 FRAME RD NEWBURGH. IN 47630 ID PREFIX TAG REGULATORY OR SUMPLIFY OR SUMPLIFY OR SUMPLIFY ACTION SHOULD BE CROSS-RECEPTON (LACH ORBITAL ACTION SHOULD BE CROSS-RECEPTON SHOULD BE CROSS-RECEPTON COMPLETION DATE **CASH TAG PROPRIATE COMPLETION DAT		of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155252	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/04/2013
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Was provided with only a single layer of five eights inch drywall on the ceiling which did not meet the one hour fire resistance rating. The Maintenance Director confirmed this room was used for oxygen storage and oxygen transferring at the time of observation. 3.1-19(b) PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE (EA			4088 F	RAME RD	
five eights inch drywall on the ceiling which did not meet the one hour fire resistance rating. The Maintenance Director confirmed this room was used for oxygen storage and oxygen transferring at the time of observation. 3.1-19(b) Additional Ceiling installed in oxygen room to provide at least a 1 hour fire resistive rating. No further corrective action required. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: No further corrective action required. Systemic changes will be	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION
		was provided with only a single layer of five eights inch drywall on the ceiling which did not meet the one hour fire resistance rating. The Maintenance Director confirmed this room was used for oxygen storage and oxygen transferring at the time of observation.		recur are as follows: Additional Ceiling installed in oxygen room to provide at lea 1 hour fire resistive rating. No further corrective action required to the monitored and a quality assurance program implemented to ensure the deficient practice will not reper the following: No further corrective action required. Systemic changes will be	ast a o red.

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